

S.M., Appellant

**U.S. POSTAL SERVICE, POST OFFICE,
Burlington, VT, Employer**

Appearances:

Benjamin Zimmermann, Esq., for the appellant¹
Office of Solicitor, for the Director

Case Submitted on the Record

Before:

JURISDICTION

¹ In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

² 5 U.S.C. § 8101 *et seq.*

³ Appellant filed a timely request for oral argument in this case. By order dated March 14, 2018, the Board exercised its discretion and denied appellant's request as oral argument would further delay issuance of a Board decision and not serve a useful purpose. *Order Denying Request for Oral Argument*, Docket No. 17-1491 (issued March 14, 2018).

ISSUE

The issue is whether appellant has met his burden of proof to establish that acceleration of osteoarthritis in his left knee is causally related to the accepted factors of his federal employment.

FACTUAL HISTORY

On March 27, 2015 appellant, then a 67-year-old retired letter carrier, filed an occupational disease claim (Form CA-2) alleging that he sustained acceleration of osteoarthritis of the left knee as a result of factors of his federal employment. He noted that he first became aware of his claimed condition and of its relationship to his federal employment on February 12, 2015. Appellant retired from federal service, effective January 16, 2015.

In support of his claim appellant submitted a series of medical reports. In a diagnostic report dated December 14, 2000, Dr. Steven Nudo, a Board-certified orthopedic radiologist, examined the results of an x-ray of appellant's left knee to rule out a fracture due to a fall. He observed that the bones and soft tissue were within normal limits and no fracture was identified.

In a report dated July 9, 2003, Dr. Kristen Destigter, a Board-certified diagnostic radiologist, examined the results of an x-ray of appellant's left knee. She noted mild narrowing of the lateral compartment with bony proliferation, as well as narrowing and bony proliferation of the patellofemoral joint.

On December 14, 2004 Dr. Robert Johnson examined appellant and expressed uncertainty as to the cause of appellant's symptoms. He noted that a magnetic resonance imaging (MRI) scan had been performed and that it demonstrated a lateral meniscus extended from the joint in a dramatic fashion. Dr. Johnson noted that it was possible that appellant continued to crush his lateral meniscus and deformed it further, causing impingement. He recommended that appellant keep a diary of issues with his joint and return in four to six weeks for further evaluation.

In a report dated January 13, 2005, Dr. Johnson noted that appellant had continued lateral knee pain postarthroscopic debridement of his left lateral meniscus. At the time of this procedure, it was noted that appellant had several grade 1 and grade 2 lesions on his lateral tibial plateau and a grade 4 lesion that underwent microfracture in 2003. Dr. Johnson noted that it was likely that appellant would continue to have pain with his arthritis, and that his examination was consistent with some decreased joint space on the left side, as appellant opened up with a valgus stress.

On February 15, 2005 Dr. Stephen Incavo, a Board-certified orthopedic surgeon, diagnosed lateral component arthritis of the left knee. He reiterated this diagnosis on May 20 and 27, 2005.

In a report dated June 7, 2005, Dr. Scott Luria, a Board-certified internist, diagnosed knee arthritis and performed an injection.

In a diagnostic report dated February 3, 2010, an unnamed physician examined the results of x-rays of appellant's knees. The physician noted mild stable degenerative changes in the right knee and moderate stable degenerative changes in the left knee.

In a diagnostic report dated March 16, 2011, Dr. David Halsey, a Board-certified orthopedic surgeon, examined the results of an x-ray of appellant's knees. He noted impressions of the left knee of a small joint effusion, moderate degenerative changes in the lateral foraminal compartment, as well as enthesopathic changes to the inferior pole of the patella intimate with the proximal insertion of the patellar tendon.

On April 13, 2011 Dr. Halsey diagnosed degenerative joint disease of the left knee. He performed a corticosteroid injection.

Appellant submitted several reports signed by nurse practitioners to the case file, including a report dated September 29, 2011.

In a diagnostic report dated May 23, 2012, Dr. Halsey examined the results of an x-ray of appellant's knees. With regard to the left knee, he observed a small amount of fluid in the suprapatellar process, moderate-to-severe degenerative changes in the lateral femerotibial compartment, moderate degenerative changes on the patellofemoral compartment, and mild degenerative changes on the medial femorotibial compartment. Dr. Halsey further noted minimal spurring of the tibial spines.

On September 4, 2013 Dr. Halsey reviewed x-rays of appellant's left knee, demonstrating grade 3 Kellgren-Lawrence osteoarthritis with obliteration of the joint space and localized to the lateral compartment.

By letter dated November 25, 2014, appellant indicated that he began work as a letter carrier in 1984 and had no problems with his knee until he began to deliver a new route that involved going up and down many steep stairs, up to 10 hours per day and 6 days per week. He further noted that he had to enter and exit his postal vehicle numerous times to deliver mail and parcels, frequently crawling on his hands and knees in the back of the truck to retrieve deliverables. Appellant changed routes about in 2004, but still had to climb flights of stairs to deliver mail, as well as walking up and down steep hills. He stated that sorting mail involved bending and lifting boxes of mail, pivoting to case the mail, and transferring trays of mail weighing up to 50 pounds from large hampers into the backs of vehicles. Appellant used two bags to carry most of his mail up and down steep stairs and into the backs of vehicles, walking around six miles per day on the route in which he first experienced knee pain. He noted that he used to hike, bicycle, and lift weights a few times per week, but had to stop after his knee began to hurt in 2003. Appellant stated that he was not supposed to lift more than 50 pounds.

By letter dated February 12, 2015, Dr. David Morley, Jr., a Board-certified orthopedic surgeon, reviewed his treatment of appellant and diagnosed left knee arthritis. He noted that he examined appellant on that date for left knee problems including pain, swelling, loss of motion, and functional limitations, which occurred progressively over the course of appellant's federal employment. Dr. Morley noted, "After a careful history, physical examination, and review of documentation provided -- including radiographic reports, it is my professional opinion, within a reasonable degree of medical certainty, that [appellant] sustained accumulative injuries to his left knee resulting in progressive deterioration of the left knee secondary to overuse arthritis." He further noted that appellant's left knee symptoms ultimately required a total knee replacement which led to his retirement. Dr. Morley explained that the etiology of degenerative arthritis, while not clearly delineated, was ultimately the failure of articular cartilage resulting in progressive loss

of the cartilage along with inflammation associated with loss of motion, stiffness, rest and activity-related pain, gait abnormality, and progressive deterioration of function. He noted that there was scientific evidence that factors contributing to osteoarthritis included heavy impact loading activities such as standing, walking, kneeling, stooping, bending, twisting, and climbing. Dr. Morley noted that these were the kinds of physically demanding activities that appellant performed in his capacity as a letter carrier. He explained, “The repetitive heavy physical activities, as described above, have resulted in increased stresses through [appellant’s] left knee contributing to his left knee arthritis,” and reiterated his professional opinion that the most likely cause of his condition was degenerative and causally related to the physical duties of a letter carrier. Dr. Morley also reiterated his belief that there was a direct causal relationship between appellant’s arthritis and his work, noting that such a relationship of aggravation/acceleration due to such duties was well documented and a classic example of such a case. He clarified that the aggravation of the underlying arthritis process was permanent rather than temporary and that all opinions in this letter were provided within a reasonable degree of medical certainty.

On September 4, 2013 Dr. Halsey diagnosed left knee lateral compartment osteoarthritis. He noted that appellant informed him that he substituted for a lot of work at the employing establishment and that his symptoms were worsening, to the point that at the end of the day, they were so severe that he wanted to lay around in bed. Dr. Halsey recommended a left total knee arthroplasty.

By letter dated April 9, 2015, appellant’s former counsel requested that appellant’s claim be submitted to a district medical adviser to determine the permanency and acceleration of osteoarthritis for appellant’s condition.

By development letter dated May 28, 2015, OWCP informed appellant that he had not submitted sufficient documentation to support his claim. It explained that Dr. Morley’s opinion was based, in part, on findings of diagnostic tests that had not been made available to OWCP. OWCP specified missing reports dated February 3, 2010, March 16 and September 29, 2011, May 23, 2012, and September 4, 2013. It further noted that appellant’s physician needed to provide a well-reasoned medical opinion explaining how work factors altered the natural course of his preexisting osteoarthritis of the left knee. OWCP afforded appellant 30 days to submit the necessary evidence.

On June 26, 2015 appellant’s former counsel provided OWCP with the reports dated February 3, 2010, March 16 and September 29, 2011, May 23, 2012, and September 4, 2013. Counsel noted that OWCP had requested that appellant submit a statement of causal relationship in support of his claim, yet had also acknowledged receipt of Dr. Morley’s February 12, 2015 report, which addressed causation in detail.

On July 1, 2016 OWCP referred appellant’s claim for a second opinion on the issue of whether he sustained an aggravation of his left knee osteoarthritis and whether his claimed injury was permanent or temporary.⁴

⁴ However, a letter informing appellant of the referral does not appear in the case record, nor does any further pursuit of a second opinion appointment by OWCP.

By decision dated August 26, 2016, OWCP denied appellant's claim finding that he had not submitted sufficient evidence to establish causal relationship between his diagnosed condition and the accepted factors of his federal employment. It explained that it had not received the diagnostic reports requested in its development letter of May 28, 2015, and further noted that a report existed in the record of x-rays after a fall on December 14, 2000. OWCP noted that it did not receive medical reports leading up to these x-rays, or treatment received afterward, nor did it receive medical reports for treatment leading up to a January 20, 2003 surgery and any follow-up case from February through June 2003, nor medical reports for treatment received after a January 19, 2014 surgery. As such, OWCP denied appellant's claim, finding that Dr. Morley's February 12, 2015 report was not based on an accurate medical history.

On September 13, 2016 appellant's formal counsel requested an oral hearing before an OWCP hearing representative. He attached a memorandum arguing that Dr. Morley's report was, in fact, based on an accurate medical history and a thorough review of the medical and factual evidence. Counsel further noted that the records OWCP had found missing and determinative in this case were sporadic and random selections not required to support what is already established in medical records to which OWCP already had access.

In a supplemental report from Dr. Morley dated January 26, 2017, he reviewed medical records subsequent to his February 12, 2015 report. He explained that these records did not change his opinion that appellant's left knee arthritis was aggravated by cumulative injuries to his left knee while performing duties of his federal employment. Dr. Morley noted that with respect to the January 16, 2014 left total knee replacement, the medical notes that he reviewed supported the proposition that because of persistent work-related factors, appellant underwent that procedure and was forced to retire.

Attached to the memorandum were medical reports dated between December 14, 2000 and February 3, 2010. Appellant submitted a note from a physician assistant dated December 14, 2000, in which he told the physician assistant that he had fallen on ice onto his left knee cap. In a diagnostic report dated December 6, 2002, Dr. Candice Ortiz, a Board-certified diagnostic radiologist, examined the December 6, 2002 MRI scan of his left knee. She observed a complex tear involving the anterior horn and body of the lateral meniscus, a partial or full-thickness tear of the lateral collateral ligament, extensive body contusion with a small osteochondral defect of the lateral femoral condyle, joint effusion, and a Baker's cyst.⁵ In a report dated November 27, 2002, Dr. Michael Sargent, a Board-certified pediatrician specializing in pediatric sports medicine, examined appellant and diagnosed him with a probable degenerative lateral meniscal tear.

On December 12, 2002 Dr. Johnson diagnosed appellant with an injury to his left knee that resulted in moderate effusion and lack of motion, noting that the etiology was unclear as to whether it was from a lateral meniscus tear or an osteochondral defect. In a note dated February 13, 2003, he noted that appellant's pain had increased, but that his swelling had gone down. On March 20, 2003 Dr. Johnson noted that appellant's symptoms had improved significantly. In a diagnostic report dated July 9, 2003, Dr. Destigter examined an x-ray of appellant's left knee and observed mild narrowing of the lateral compartment with bony proliferation, as well as narrowing and bony

⁵ Dr. Ortiz' report refers to the medial meniscus in a section of the report referring to her impressions, but refers to the lateral meniscus when discussing her interpretation of the MRI scan related to the complex tear involving the anterior horn and body of a meniscus.

proliferation of the patellofemoral joint. On July 1, 2003 Dr. Johnson noted that appellant reported that the pain inside his knee had resolved, but that he had developed pain along the lateral neck of his gastroc muscle, the muscle belly of his anterior tibial muscle, and the tendon of his biceps femoris. He recommended that appellant cut back on his work-out regimen. Dr. Luria noted that appellant's knee surgery went well although the recovery has been prolonged. In a diagnostic report dated December 9, 2014, Dr. Michael Blankstein examined the results of an x-ray of appellant's knees.⁶ He observed a left total knee arthroplasty, with mild degenerative changes in the patellofemoral compartment, with a small suprapatellar knee joint effusion and atherosclerotic arterial calcification. On December 10, 2014 Dr. Blankstein noted that appellant was in minimal pain and with minimal swelling, and able to work full time, including ascending and descending stairs, with minimal discomfort. He noted that x-rays demonstrated components in good position with no complications.

A hearing was held on January 25, 2017. At the hearing, appellant's former counsel noted that he had submitted the medical records requested by OWCP, which were principally of no material bearing on the causation analysis. He described several of these reports, but noted that Dr. Morley's February 12, 2015 report thoroughly explained how appellant's duties contributed to his left knee arthritis. Counsel argued that Dr. Morley's report should be sufficient to establish appellant's claim. The hearing representative acknowledged that she had received the memorandum and medical records and kept the record open for 30 days for submission of additional evidence.

By decision dated April 5, 2017, the hearing representative affirmed OWCP's August 26, 2016 decision. She noted that receipt of the additional medical evidence, but she did not describe it. The hearing representative reviewed Dr. Morley's January 26, 2017 report, in which he reiterated his opinion on causation. She found that his report was insufficient to establish causal relationship because he did not explain, with adequate rationale, as to how appellant's work activities aggravated his left knee arthritis. The hearing representative quoted a portion of Dr. Morley's February 12, 2015 report in which he noted that the most likely cause of his condition was degenerative and causally related to the physical duties of a letter carrier. She further concluded that Dr. Morley had not explained why appellant's left knee osteoarthritis had been aggravated by a left knee arthroscopy on January 20, 2003.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim, including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was filed within the applicable time limitation, that an injury was sustained while in the performance of duty as alleged, and that any disability or specific condition for which compensation is claimed is causally related to the

⁶ Dr. Blankstein's Board-certification in a medical specialty could not be confirmed.

employment injury.⁷ These are the essential elements of every compensation claim regardless of whether the claim is predicated on a traumatic injury or occupational disease.⁸

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the employment factors identified by the claimant were the proximate cause of the condition for which compensation is claimed or, stated differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.

The claimant has the burden of proof to establish by the weight of reliable, probative, and substantial evidence that the condition for which compensation is sought is causally related to a specific employment incident or to specific conditions of employment.⁹ An award of compensation may not be based on appellant's belief of causal relationship. Neither the mere fact that a disease or condition manifests itself during a period of employment, nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.¹⁰

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.¹¹ Rationalized medical opinion evidence is medical evidence which includes a physician's reasoned opinion on whether there is causal relationship between the claimant's diagnosed condition and the compensable employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.¹² The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.¹³

ANALYSIS

The Board finds that this case is not in posture for decision.

⁷ Gary J. Watling, 52 ECAB 278, 279 (2001); Elaine Pendleton, 40 ECAB 1143, 1145 (1989).

⁸ Michael E. Smith, 50 ECAB 313, 315 (1999).

⁹ Roma A. Mortenson-Kindschi, 57 ECAB 418, 428 n.37 (2006); Katherine J. Friday, 47 ECAB 591, 594 (1996).

¹⁰ P.K., Docket No. 08-2551 (issued June 2, 2009); Dennis M. Mascarenas, 49 ECAB 215, 218 (1997).

¹¹ Elizabeth H. Kramm (Leonard O. Kramm), 57 ECAB 117, 123 (2005).

¹² Leslie C. Moore, 52 ECAB 132, 134 (2000).

¹³ Jennifer Atkerson, 55 ECAB 317, 319 (2004); Naomi A. Lilly, 10 ECAB 560, 573 (1959).

The Board notes that OWCP began the process of referral to a second opinion specialist on July 1, 2016, but that the process was not completed, with no explanation as to why the process was not completed in the case record. The claims development process is nonadversarial in nature and once OWCP undertakes to develop the medical evidence further, it has the responsibility to do so in a proper manner.¹⁴ The Board finds that OWCP did not complete the development of the medical record by obtaining the opinion of a second opinion physician.

On remand, OWCP should refer appellant, the case record, and a statement of accepted facts to an appropriate specialist to determine whether the identified factors of federal employment caused or aggravated his diagnosed condition. After such further development of the case record as it deems necessary, a *de novo* decision shall be issued.

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the April 5, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to further action consistent with this decision.

Issued: December 17, 2018
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

¹⁴ K.S., Docket No. 18-0845 (issued October 26, 2018); *Melvin James*, 55 ECAB 406 (2004).